Psychological Service Center
West Campus, Campus Box 1172
7 North Jackson Avenue
St. Louis, MO 63105
Phone: (314) 935-6555
Fax: (314) 300-0830

Procedure 5

Authorization for the Use or Disclosure of Protected Health Information

(HIPAA Authorization for Release of Information)

Individual Patient Name: _____

Patient's Date of Birth: _____ Home/Cell Number: _____

The Psychological Service Center at Washington University is authorized to:

☐ Release Information To:
☐ Receive Information From: **Format:** ☐ Paper copy ☐ Fax ☐ Electronic copy

Name of Individual/Institution: _____

Mailing Address: _____

City, State, Zip Code: _____

Phone Number of Individual Receiving Records: _____ Fax number: _____

Email Address*: _____

*Email is not a secure means of communication. We will encrypt email communications of your records unless you tell us you prefer us to use unencrypted email. If you prefer we not encrypt our communications to you, please initial here: _____

Purpose of Disclosure:

☐ Psychological Treatment ☐ Neuropsychological Assessment ☐ Other: _____

Date(s) of Treatment: ☐ Specific Dates: _____ through _____ ☐ All dates

Information to be Disclosed:

☐ Intake Report
☐ Termination Summary
☐ Neuropsychological report with summary of scores
☐ Neuropsychological report without summary of scores
☐ Verbal communication (no records released unless otherwise specified)
☐ Other: _____

Secondary release of information in the file from other sources not named in this authorization is

☐ Permitted ☐ Prohibited

This authorization may be revoked by a written request to The Psychological Service Center at Washington University at the address above, at any time except to the extent that action has already been taken in reliance on it. If not previously revoked, this authorization will be valid for 90 days or as specified by this date or event triggering expiration: _____.

I understand the nature and purpose of the authorization, and I had the opportunity to ask questions about it. I understand that I may refuse to sign this authorization without impact on my ability to receive treatment or benefits that I am entitled to. I understand that the information to be released may be subject to re-disclosure by the recipient (s) and may no longer be protected by the privacy regulations.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name Relationship to Individual